2012

Tampa Eye Clinic
Patient Information

❑ Dr. Creighton ❑ Dr. Scheiner
❑ Dr. Seeley ❑ Dr. Orlick
❑ Dr. Reynolds ❑ Dr. Nogales
❑ Dr. Leach ❑ Dr. Kasper
❑ Dr. Lorenzen ❑ Dr. Pravak

PLEASE PRINT CLEARLY

PATIENT NAME: LAST FIRST MIDDLE

MAILING ADDRESS: STREET/PO# ______

CITY: ______ STATE: ______ ZIP: ______

E-Mail Address:

HOME PHONE:
CELL PHONE:
SEX: ❑ MALE ❑ FEMALE
MARITAL STATUS: ❑ MARRIED ❑ SINGLE
DATE OF BIRTH:

SOCIAL SECURITY #: **DRIVERS LICENSE:** *Please allow staff to copy to place in your records*

NAME & TELEPHONE NUMBER OF PARENT OR GUARDIAN: *(if applicable)*

OCCUPATION: ❑ EMPLOYED ❑ HOMEMAKER ❑ CHILD/STUDENT ❑ RETIRED ❑ DISABLED ❑ OTHER

CO. NAME: ______ PHONE: ______

PRIMARY CARE PHYSICIAN: ______ PHONE: ______

HOW DID YOU FIND OUT ABOUT THE TAMPA EYE CLINIC? *(please check one)*

❑ INSURANCE CO. ❑ FRIEND/RELATIVE ❑ PHONE BOOK ❑ INTERNET ❑ SIGN ❑ TV/RADIO ❑ EMERGENCY ROOM ❑ EYE SCREENING

❑ MEDICAL DOCTOR *(Name):* ______ ❑ OTHER: *(please specify)* ______

IS THIS A WORKERS' COMPENSATION VISIT? ❑ YES ❑ NO DATE OF ACCIDENT: ______

WHOM TO NOTIFY IN AN EMERGENCY? (Nearest relative not living with you)

NAME: ______ RELATIONSHIP: ______

ADDRESS: ______

HOME PHONE: ______ WORK PHONE: ______

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: ______

ADDRESS: ______

ACCOUNT #: ______ GROUP #: ______

POLICYHOLDER: ______ RELATIONSHIP TO PATIENT: ______

POLICYHOLDER SS#: ______ POLICYHOLDER DATE OF BIRTH: ______

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: ______

ADDRESS: ______

ACCOUNT #: ______ GROUP #: ______

POLICYHOLDER: ______ RELATIONSHIP TO PATIENT: ______

POLICYHOLDER SS#: ______ POLICYHOLDER DATE OF BIRTH: ______

FINANCIAL ASSIGNMENT AND AGREEMENT:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any insurance carrier information needed to determine these benefits and to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance and should I default on my account, all attorney fees, interest, and collection costs are my responsibility.

I also understand that payment is expected at the time services are rendered.

______

SIGNATURE **DATE**